Irish College of General Practitioners

Health Status of Syrian Refugees in Ireland

Authors:
Claire Collins
James Larkin
Ivana Pericin

March 2019

Health Status of Syrian Refugees in Ireland

Undertaken by the Irish College of General Practitioners

Claire Collins, James Larkin and Ivana Pericin.

March 2019

Executive Summary

As a response to the humanitarian crisis in Syria, the Irish government has agreed to accept up to 4,000 refugees for resettlement in Ireland in the upcoming years under the 'Resettlement and Relocation Programmes'[1]. Prior to their arrival in Ireland, the refugees undergo a health screening carried out by the International Organisation for Migration (IOM)[2,3]. However, up until now, an overall analysis of their health needs has not taken place.

The Partnership for Health Equity, comprising University of Limerick Primary Care, HSE Social inclusion, North Dublin City GP Training and the ICGP, initiated a project focused on investigation of the health needs of Syrian refugees. This research was carried out by the ICGP, funded by the HSE National Social Inclusion Office and supported by the Irish Department of Justice and Equality. The project used self-completed questionnaires with refugees who have arrived to Ireland in the last year, asking them to self-report their health status.

The SafetyNet primary care unit conducted an initial assessment of each refugee on arrival in Ireland. SafetyNet Primary Care is commissioned by HSE Social inclusion to conduct health screening of refugees under the Irish Refugee Protection Programme. As part of this project, individuals were asked for consent to permit analysis of their SafetyNet consultation data. Of the 195 refugees aged 16 years and older who consented and completed questionnaires in this study, 134 also consented to the secondary analysis of their health data as collected by SafetyNet. Of this 134, data was available for 116 individuals.

Syrian Refugees in Ireland consist of a relatively young cohort; in this study the majority of participants were younger than 35 years and male (59%). The overall health status was reported to be good or very good by two thirds of survey respondents. The most common health condition was found to be headache and the most common medications used were painkillers. Almost half of respondents (46.5%) smoked daily/occasionally, which is much higher in comparison with the Irish population. Health symptoms which occurred most frequently were 'difficulty falling asleep', 'feeling hopeless about future' and a 'sudden emotional or physical reaction when reminded of the most hurtful or traumatic events'. The significance of these factors need to be considered and monitored.

A high number of refugees had attended a general practitioner regarding their health issues, with a small number having accessed other healthcare providers. The majority of refugees expressed that they did not experience unmet health needs in Ireland.

During their GP assessment, one quarter of refugees were found to have one acute condition, and a fifth of refugees had one chronic condition. Also of those who had their blood pressure checked, 28% had high blood pressure.

The greatest need appeared to be dental with 61.1% of those who had a SafetyNet consultation found to be in need of dental care. Another high need was in relation to vision; 31.7% of refugees were found to have an issue with their vision. For mental health conditions, the patient health questionnaire was used in SafetyNet consultations to assess psychological distress; 21% reported mild psychological distress while 8% and 5% had moderate and severe psychological distress respectively. 13.3% of refugees were also considered to have a 'mental health issue'. The data from the self-completed questionnaires revealed that 18% of those who completed the HSCL-10 were classified as being 'in psychological distress'.

Of particular note with regard to health need is the rate of pregnancies; 15% of female refugees were pregnant at the time of SafetyNet consultation.

Immediate requirements for health care relate to dental health, maternity care and mental health.

When investigating the reasons for dissatisfaction, conditions of their living environment, transport and financial situation were mentioned most frequently. Social environments impact on acculturation and on health. A focus on this area may return notable benefits to the overall health and integration of Syrian Refugees now resident in Ireland.

There is a need to prepare more widely for when Syrian individuals and families move from the EROCs into the community. As a first step, the relevant stakeholders have agreed to collaborate to prepare information for GPs to create awareness about the health requirements of this group and the services and supports available. This will be available by mid-2019.

Introduction

The conflicts which took place in Syria initiated one of the largest humanitarian crises to date, causing external and internal displacement of millions of people[4,5]. As a result of the displacements, more than one million refugees and migrants sought asylum in the European Union[5]. In order to address the refugee crisis and assist the EU states who are most exposed to refugee flows, the EU members agreed to take part in a resettlement scheme[5,6]. As a part of the EU resettlement scheme, Ireland has committed to accepting 4,000 refugees in the coming years[1].

Prior to their arrival in Ireland, refugees commonly faced precarious living conditions, including being accommodated in unsafe, overcrowded spaces, without basic hygiene requirements[7]. A lack of access to education, social assistance, protection and medical care were reported as well[7]. After their arrival in Ireland, refugees are accommodated in temporary accommodation centres known as Emergency Response and Orientation Centres (EROC centres)[8]. The aim of these centres is to provide a stable, supportive and safe environment for refugees, prior to their housing in permanent homes across Ireland[8]. The EROC centres also provide access to medical, language training, education, cultural orientation and social protection services for all the residents[8]. Although medical healthcare services are available, considering that refugees have a variety of health needs that differ from the general population, adequate care for this vulnerable group requires the appropriate allocation of resources. Therefore, it is necessary for policy makers and healthcare providers to understand the healthcare needs of this group in order to provide for them appropriately. Currently, it is not clear what level of healthcare is needed for refugees in Ireland as there is very little information on their health status available.

Therefore, the ICGP in collaboration with the Irish Department of Justice, the International Organisation for Migration (IOM) and the National Office for Social Inclusion HSE initiated a project focused on investigation of the health needs of Syrian refugees. The project was funded by the National Office for Social Inclusion HSE.

The project included administration of self-completed questionnaires to refugees who have arrived to Ireland in the last year, asking them to self-report their health status. The questionnaires required respondents to provide their sociodemographic and migration information, health status, health related quality of life, and unmet health needs. The questionnaire was cross culturally validated and available in both English and Arabic. During questionnaire administration, translators were present in order to assist those with literacy issues. In addition, this research carried out in Ireland mirrors the work carried out in Norway, and the results of the questionnaires from both countries will be compared at the later stages of the study in order to provide context and generalisability.

The SafetyNet primary care unit conducted an initial assessment of each refugee on arrival in Ireland. The assessment, conducted as a GP consultation, covered several areas including: administrative details, physical health, mental health, social health, infectious disease screening, immunisation and onward referral. As part of this project, individuals were asked for consent to permit analysis of their SafetyNet consultation data. Of the 195 refugees aged 16 years and older who consented and completed questionnaires in this study, 134 also consented to the secondary analysis of their health data as collected by SafetyNet. Of this 134, data was available for 116 individuals. Ethical approval for the project was obtained from the ICGP Research Ethics Committee.

Results – Self-Reported Health Status

In total, 194 questionnaires were completed by the residents of the EROC Centres, located across Ireland, including the centres in Ballaghaderreen, Clonea, Mosney and Monasterevin. Overall the majority of respondents stated that they were from Syria (95.3%, n=182), in the age range 18-34 (69.3%, n=104) and married (71.9%, n=138) (Table 1). The survey respondents are found to be representative with the overall Syrian population in Ireland, regarding gender and age range (see Appendix 1).

Table 1. Demographics

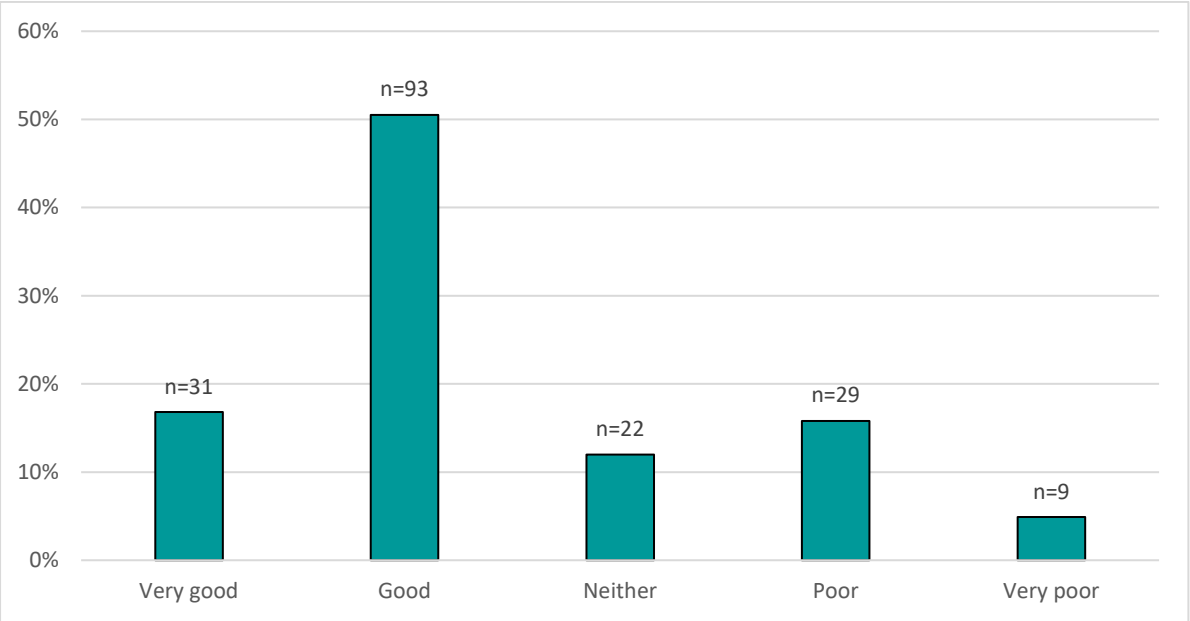
	%	n
Gender		
Female	41.1	79
Male	58.9	113
Age group		
18-24	30.0	45
25-34	39.3	59
35-44	18.0	27
45-54	10.7	16
55-64	2.0	3
Country of birth		
Syria	95.3	182
Iraq	4.2	8

Marital status		
Single	21.9	42
Married	71.9	138
Divorced	1.6	3
Widowed	3.1	6
Occupational status in the country of origin		
Employed for wages	12.6	23
Self-employed	23.6	43
Out of work	4.9	9
Homemaker	23.6	43
Student	24.2	44
Unable to work	1.1	2
Other	9.3	17

The questionnaires revealed that the majority of refugees left their country of origin in the period from 2013 to 2016 (76.3%, n=148) and arrived to Ireland in 2017 (68.8%, n=99), with all members of their immediate family (55.8%, n=106). During their journey to Ireland, a high number of refugees stayed in two or more transition countries for longer than one week (83.1%, n=148). The residence period in transition countries for majority was longer than one year (77.6%, n=131). Overall, 2.4% (n=4) of refugees stayed in a transit country for up to six months, 20.1% (n=34) six to twelve months, 45.6% (n=77) one to two years and 32.0% (n=54) for more than two years.

Regarding overall health status, 67.3% of refugees (n=124) expressed that their health was either 'very good' or 'good' at present (Figure 1), and 74.9% (n=128) were without physical pain which lasted for more than six months.

Figure 1. Overall self-expressed health



The vast majority of refugees (65.3%, n=126) did not have any of the health issues proposed by the questionnaire. The most common health conditions amongst respondents were headache (10.3%, n=20), other joint disease (8.8%, n=17), arthritis (8.2%, n=16) and mental health problems (8.2%, n=16) (Table 2).

Table 2. Percentages of the total population with self-reported health conditions

	Yes	
	%	n
Headache	10.3	(20)
Other joint disease	8.8	(17)
Arthritis	8.2	(16)
Mental health problems	8.2	(16)
Allergies	7.3	(14)
Abdominal pain/diarrhea	6.3	(10)
Diabetes	4.6	(9)
Kidney disease	4.1	(8)
Eczema	3.1	(6)
Chronic bronchitis, emphysema or COPD	2.1	(4)
Osteoporosis	2.1	(4)

Other heart diseases	1.3	(2)
Asthma	1.0	(2)
Fibromyalgia	1.0	(2)
Heart attack/chest pain	1.0	(2)

Regarding medication, painkillers are found to be the most consumed on a weekly or daily basis by refugees. Overall 13.8% (n=26) of all respondents used prescribed painkillers and 13.1% (n=25) used painkillers without prescription. Painkillers were followed by medicine for high blood pressure (7.9%, n=15) and drugs for peptic ulcer (6.8%, n=13) (Table 3).

Table 3. Percentages of the total population with self-reported use of medication

	Daily to weekly	
	%	n
Painkillers, on prescription	13.8	(26)
Painkillers, off prescription	13.1	(25)
Medicine for high blood pressure	7.9	(15)
Drugs for peptic ulcer, gastro-esophageal reflux and digestion	6.8	(13)
Antithrombotics (aspirin, warfarin)	5.8	(11)
Anti-depressive medication	5.3	(10)
Tranquilizers	5.3	(10)
Medicine for diabetes mellitus	5.3	(10)
Sedatives	4.7	(9)
Other prescribed medication, but do not know for what	4.3	(8)
Cholesterol reducing medication	3.7	(7)
Medication for allergy	3.2	(6)
Medication for asthma	1.6	(3)

Table 3a. Percentages of medications taken by respondents who have at least one health condition

	Daily to weekly	
	%	n
Painkillers, on prescription	30.3	(17)
Painkillers, off prescription	29.9	(17)
Medicine for high blood pressure	17.5	(10)
Drugs for peptic ulcer, gastro-esophageal reflux and digestion	15.8	(9)
Medicine for diabetes mellitus	12.3	(7)
Antithrombotics (aspirin, warfarin)	12.3	(7)
Tranquilizers	12.3	(7)
Anti-depressive medication	10.5	(6)
Cholesterol reducing medication	8.8	(5)
Sedatives	7.2	(4)
Medication for allergy	7.1	(4)
Other prescribed medication, but do not know for what	5.3	(3)

In the week prior to completing the questionnaires, participants most commonly expressed that they had 'quite a bit' or 'extreme' difficulty falling asleep (25.2%, n=36), 'feeling blue' (25.0%, n=37) and 'feeling hopeless about the future' (20.4%, n=30). Of participants who expressed that they feel 'extremely' or 'quite a bit' hopeless about the future, eight (26.7%) reported to have mental health issues and three (10.0%) take anti-depressive medication daily/weekly.

The Hopkins Symptom Checklist (HSCL-10) and the Harvard trauma questionnaire (HTQ) were included in the overall questionnaire to screen for psychological distress and symptoms of post-traumatic stress disorder (PTSD). For each questionnaire, at least half of the questions had to have been answered for the response to be considered valid. Amongst those who responded to the HSCL-10, 18.0% (n=35) were above the threshold for someone in psychological distress. For the HTQ, 4.6% (n=9) were considered symptomatic for PTSD.

Regarding behavioural risk factors, the questionnaires revealed that the majority of refugees have never smoked (50.3%, n=87) or never drank alcohol (71.7%, n=119), while 46.5% (n=80) self-reported that they currently smoke and 23.1% (n=39) that they currently drink alcohol.

Of the ones who smoke cigarettes, 29.5% (n=51) smoke daily and 8.1% (n=14) occasionally. Regarding physical activity, 31.7% (n=51) never exercise, 19.3% (n=31) exercise 2-3 times a week and 18.0% (n=29) nearly every day. All refugees who answered a question regarding drug misuse responded negatively (100%, n=145).

The 'health related quality of life' section of the questionnaire was analysed by applying descriptive statistics (Table 4 and Table 5) and the WHOQOL-BREF instrument (Table 6).

The descriptive statistical analysis revealed that 60.9% (n=112) of participating refugees rated their quality of life as good or very good. More than two thirds of respondents reported that they were satisfied or very satisfied about their overall health (67.7%, n=122), personal relationships (82.1%, n=142) and themselves (76.9%, n=120). However, the satisfaction rates were lowest regarding place of residence/living conditions, where less than half of participants were satisfied or very satisfied with their living surroundings (39.9%, n=69) (Table 4). This is reflected in the mean ratings where living conditions shows the lowest mean score overall; the highest being satisfaction with personal relationships.

Table 4. Level of satisfaction with quality of life and services provided

	Very satisfied	Satisfied	Neither	Dissatisfied	Very dissatisfied	Mean score
	% n	% n	% n	% n	% n	
How satisfied are you with your health	14.4 (26)	53.3 (96)	11.7 (21)	16.1 (29)	5.4 (8)	3.57
How satisfied are you with your personal relationships	15.0 (26)	67.1 (116)	10.4 (18)	5.2 (9)	2.3 (4)	3.87
How satisfied are you with yourself	14.8 (25)	62.1 (105)	13.0 (22)	7.1 (12)	3.0 (5)	3.79
How satisfied are you with your transport	9.1 (16)	47.4 (83)	17.7 (31)	14.3 (25)	11.4 (20)	3.29
How satisfied are you with your access to health services	8.0 (14)	52.0 (91)	20.0 (35)	9.1 (16)	10.9 (19)	3.37
How satisfied are you with your ability to perform your daily living activities	6.5 (11)	54.2 (91)	21.4 (36)	13.7 (23)	4.2 (7)	3.45

How satisfied are you with the conditions of your living place	5.2 (9)	34.7 (60)	23.7 (41)	16.8 (29)	19.7 (34)	2.89
How satisfied are you with your sleep	5.1 (9)	59.3 (105)	17.5 (31)	10.2 (18)	7.9 (14)	3.44

Overall, more than one quarter of respondents expressed that the financial support (27.6%, n=47) and leisure activities (17.9%, n=31) provided were insufficient for their needs.

Regarding safety in daily life, only five (2.9%) respondents did not feel safe at all, while 64.9% (n=113) felt very much or extremely safe (Table 5).

Table 5. Perspectives on everyday life

	Not at all	A little	Moderate amount	Very much/ mostly	Extreme amount/ completely
	% n	% n	% n	% n	% n
Have you enough money for your needs	27.6 (47)	26.5 (45)	36.5 (62)	5.9 (10)	3.5 (6)
To what extent do you have the opportunity for leisure activities	17.9 (31)	32.4 (56)	34.7 (60)	11.6 (20)	3.5 (6)
To what extent do you feel your life is meaningful	9.4 (16)	19.9 (34)	33.3 (57)	28.1 (48)	9.4 (16)
How healthy is your physical environment	8.6 (15)	12.6 (22)	34.5 (60)	31.0 (54)	13.2 (23)
How much do you enjoy life	8.1 (14)	27.2 (47)	37.0 (64)	23.7 (41)	4.0 (7)
How available to you is the information that you need in your day to day life	7.3 (12)	26.8 (44)	44.5 (73)	18.3 (30)	3.0 (5)
How safe do you feel in your daily life	2.9 (5)	9.2 (16)	23.0 (40)	49.4 (86)	15.5 (27)
Do you have enough energy for everyday life	1.8 (3)	18.8 (32)	32.4 (55)	40.0 (68)	7.1 (12)

In order to analyse health related quality of life, the WHOQOL-BREF scoring instructions were applied as well (Table 6). The WHOQOL-BREF instrument is based on four main domains, including physical health, psychological, social relationships and environment. On the scale 4 to 20, where higher values represent a better quality of life, the highest means were observed for the social relationships domain ($\bar{x}$ =14.7) and the lowest for the environment domain ($\bar{x}$ =12.0).

Table 6. Summary of the WHOQOL-BREF domains

	n	Mean	Minimum	Maximum	Std. Deviation
Physical health	163	14.4	5.14	20.0	2.8
Psychological	164	13.5	7.2	20.0	2.6
Social relationships	168	14.7	4.0	20.0	2.9
Environment	168	12.0	5.0	19.0	2.8

The questionnaire revealed that the most visited health care providers were general practitioners, accounting for almost 80% of respondents (79.3%, n=130) with reports of at least one consultation in a GP practice in the last 12 months (Figure 2). In total, over half of the respondents highlighted that they did not experience unaddressed health needs in the places they have resided (57.2%, n=83) and if needed they were familiar with where to find appropriate healthcare in their current residence (63.1%, n=106). When asked did they or their family members receive the medical assistance they needed in Ireland, 27.6% (n=45) of the participants said completely, 44.2% (n=72) moderately, 24.5% (n=40) a little and 3.7% (n=6) not at all.

On the other side, 42.8% (n=62) experienced unmet health needs. Of these respondents 53.1% (n=33) experienced unmet health needs in a transit country, 27.4% (n=17) in Ireland and 19.4% (n=12) in both transit country and in Ireland (Figure 3). More than a third of the participants who have experienced unmet health needs (35.7%, n=20) considered their health to be ‘poor’ or ‘very poor’, with mental health problems (21.0%, n=13), headache (16.1%, n=10) and other joint diseases (16.1%, n=10) highlighted as the most common conditions.

Figure 2. Visits to health care providers in the last 12 months

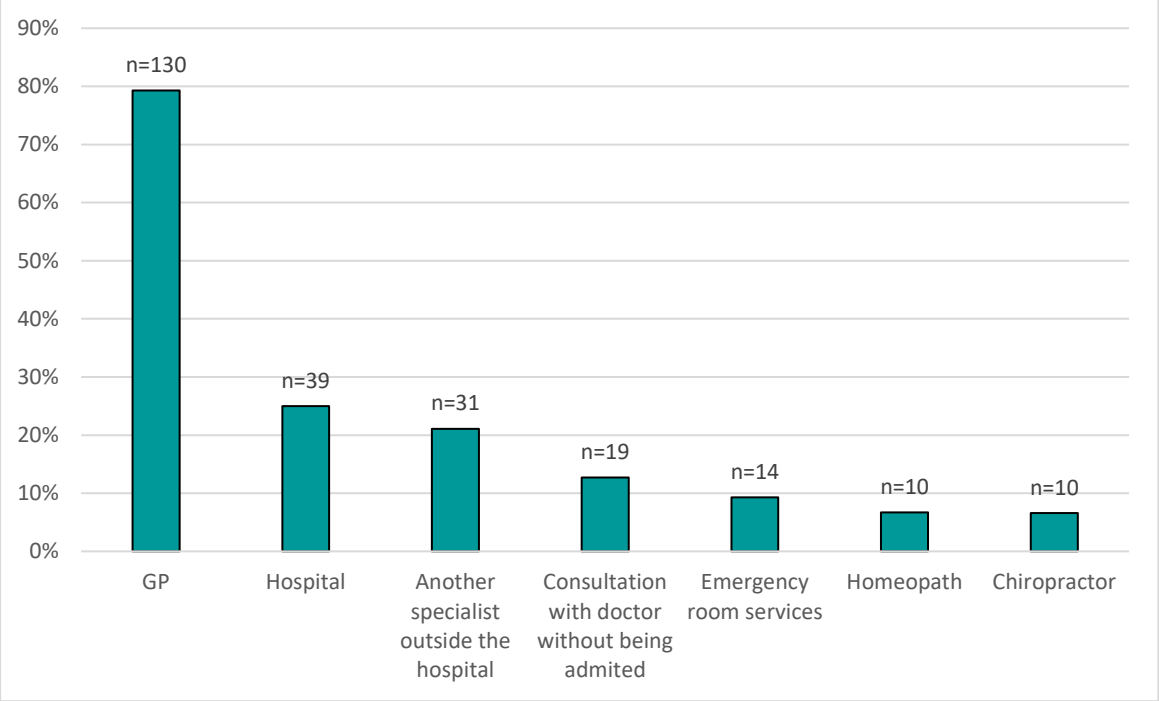


Figure 3. Place of residence when experienced unmet health needs

Results – Comparison of GP Assessed Health and Self-Reported Health Status

Amongst those who consented, 54.3% (n=63) were located in the Ballaghaderreen EROC, 30.2% (n=35) were located in the Clonea EROC, 12.1% (n=14) were located in the Monasterevin EROC and 3.4% (n=4) were located in the Mosney EROC.

The average age of refugees was 30.0 years (*SD*=9.5, range=18-63). Further information on demographics are shown in Table 7.

Table 7. Gender and age of refugees

	%	N
Gender		
Male	58.6	68
Female	41.4	48
Age		
16/17	0	0
18-24	33.6	39
25-29	18.1	21
30-34	20.7	24
35-39	12.1	14
40-44	6.9	8
45+	8.6	10

The patient health questionnaire-4 (PHQ-4) was administered by a GP. The PHQ-4 is a brief measurement of depression and anxiety. According to the results of the screening, 4.8% (n=3) had 'severe' psychological distress, 7.9% (n=5) had 'moderate' psychological distress, 20.6% (n=13) had 'mild' psychological distress, and 66.7% (n=42) had no psychological distress. Eighty three of the refugees had their mental health status recorded. From the consultations, 13.3% (n=11) of refugees were classified as having a 'mental health issue'.

Refugees were assessed for current medical conditions. This was then divided into acute and chronic; 26.7% (n=31) of refugees were found to have one acute condition, 0.9% (n=1) were found to have two acute conditions, and 72.4% (n=84) had no acute conditions. Common acute conditions included low mood and skin infections. A fifth (20.7%, n=24) of refugees had one chronic condition, 4.3% (n=5) had two chronic conditions, and 75% (n=87) had no chronic conditions. Common chronic conditions included myopia, chronic pain and hypertension.

For those whose vision was checked, 31.7% (n=26) had some problem. Dental problems were common with 61.1% (n=58) of those assessed being described as having dental needs.

It was also found that 20.0% (n=14) of refugees for whom a medication entry was made were taking medications.

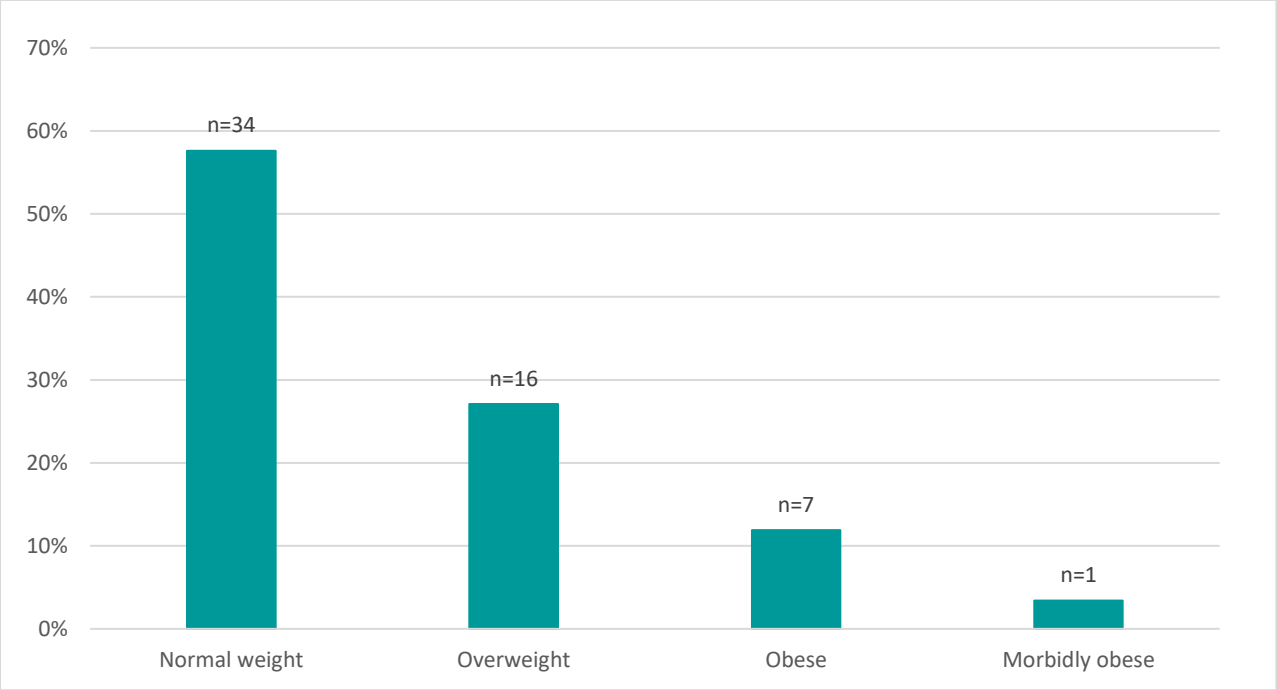
Amongst the female refugees, 14.6% (n=7) were pregnant.

Overall, 86 refugees were asked if they were smokers, 51.2% (n=44) of these said they smoked, 9.3% (n=8) said they were former smokers and 39.5% (n=34) said they had never smoked. Smokers were classified as those who smoked cigarettes, a pipe, or shisha.

Amongst refugees who were asked if they drink alcohol, 14.0% (n=12) said they did, while 86.0% (n=74) said that they did not.

BMI was recorded for 59 people, and their average BMI was 24.6 (*SD*=5.4). Details of weight status are shown in Figure 4.

Figure 4. Weight status of refugees



Amongst those who had their blood pressure checked, 27.7% (n=23) had high blood pressure (systolic blood pressure ≥ 140 and/or diastolic blood pressure ≥ 90) and 72.3% (n=60) did not.

Table 8 compares the data collected at the SafetyNet assessment and self-reported data collected as part of the follow-up research study. While variations existed in the mode of data collection, similar results were evident. Overall, this analysis revealed that approximately one quarter of refugees have a chronic condition; in the region of half were smokers; and approximately two in five have a mental health problem/psychological distress.

Table 8. Variables comparable to questionnaire data

Questionnaire Recorded %	SafetyNet Recorded %
Smoker	
46.5 (n=80)	51.2 (n=44)
Consumes alcohol	
23.1 (n=39)	14.0 (n=12)
Currently taking medication*	
33.7 (n=64)	20.0 (n=14)
Medical Condition¥**	
N.A.	45.7 (n=53)
Acute medical condition**	
N.A.	27.6 (n=32)
Long Term (≥ 1 yr) Illness**	**Chronic medical condition****
24.0 (n=42)	25.0 (n=29)
'Mental health problem'**	**'Mental health issue'****
21.0 (n=13)	13.3 (n=11)
Psychological distress**	**Severe/moderate/mild Psychological distress****
18.0 (n=35)	4.8 (n=3) 7.9 (n=5) 20.6 (n=13)

*Question phrased differently.

** SafetyNet data was recorded by the GP during assessment while the research data was self-reported on the basis of a series of specific, direct questions on a questionnaire.

¥ Acute, Chronic and Mental Health combined

Discussion and Conclusions

Syrian Refugees in Ireland consist of a relatively young cohort; in this study the majority of participants were younger than 35 years and male (59%). The Syrian population, overall, has been described as having a 'young age structure' with 58% of the population younger than 24[9]. In a study[10] of a random sample of 352 Syrian refugees based in a 'tent-city' in Turkey, the average age of respondents was 37.6 years and the gender breakdown was approximately 50-50.

The overall health status was reported to be good or very good by two thirds of survey respondents. Only a small number of refugees experienced the health issues listed on the questionnaire. The most common health condition was found to be headache and the most common medications used were painkillers. The majority of refugees did not drink alcohol or misuse substances. However, almost half of respondents (46.5%) smoked daily/occasionally, which is much higher in comparison with the Irish population. Health symptoms which occurred most frequently were 'difficulty falling asleep', 'feeling hopeless about future' and a 'sudden emotional or physical reaction when reminded of the most hurtful or traumatic events'. In each case, between a fifth and a quarter of respondents stated they had the respective symptom.

When investigating the reasons for dissatisfaction, conditions of their living environment, transport and financial situation were mentioned most frequently. Most notably, only 40% of survey respondents were satisfied with their living surroundings.

A high number of refugees had attended a general practitioner regarding their health issues, with a small number having accessed other healthcare providers. The majority of refugees expressed that they did not experience unmet health needs in Ireland; 27% of survey respondents reported that they had an unmet health need in Ireland.

Comparison to data from Norway and the Lebanon using the same questionnaire indicates that the proportion of respondents who self-reported health conditions in the main was lower in Ireland. The proportion reporting daily/weekly use of medication was higher for most medications listed on the questionnaire in Ireland compared to the Lebanon and Norway. We also noted that the prevalence of trauma exposure and anxiety/depression (HSCL-10) is substantially lower among the Syrians in Ireland, although daily use of tranquillisers, sedatives and anti-depressants is higher, compared to Norway and the Lebanon. Respondents' access/use of various health services were similar in Ireland and Norway, although substantially lower in the Lebanon.

However, it appears that the Irish system may be more accessible and serving the needs of this population compared to the Norweigan system with a higher proportion in Ireland reported knowing where to find healthcare if needed, and a lower proportion reporting they had not received the care needed at all.

With regard to health need, of note is the rate of chronic and acute conditions. About a quarter of refugees were found to have one acute condition, and a fifth of refugees had one chronic condition. Only 1% had two acute conditions and 4% had two chronic conditions. Also, of those who had their blood pressure checked, 28% had high blood pressure.

The greatest need, identified by the GP assessments, appeared to be dental with 61.1% of those who had a SafetyNet consultation found to be in need of dental care. Dental/oral health was not explicitly asked about in the self-reported questionnaires and hence did not arise as an issue. Another high need was in relation to vision; 31.7% of refugees were found to have an issue with their vision. This proportion appears relatively high given the young sample – it is estimated that 4.7% of the general population in Ireland have 'low vision and sight loss'[11]. For mental health conditions, the patient health questionnaire was used in SafetyNet consultations to assess psychological distress; 21% had mild psychological distress while 8% and 5% had moderate and severe psychological distress respectively. Also 13.3% of refugees were considered to have a 'mental health issue'. The data from the self-completed questionnaires revealed that 18% of those who completed the HSCL-10 were classified as being 'in psychological distress'. In a survey[12] of Arabic speaking refugees in 'collective centres' in Germany, only 35.7% were found to have no 'mental distress', compared to 67% of participants in this study (according to SafetyNet data). The study in Germany classified mental distress as the presence of PTSD and/or depression and/or anxiety[12]. Therefore, there appears to be lower levels of psychological distress in Syrian refugees in Ireland relative to other groups of Syrian refugees.

Of particular note with regard to health need is the rate of pregnancies; 15% of female refugees were pregnant at the time of SafetyNet consultation.

There appears to be a high rate of smoking amongst Syrian refugees with approximately half of participants smoking shisha, pipes or cigarettes. In 2017 in Ireland, 22% of people aged 15 and over self-reported that they are smokers[13]. A cross-sectional study of Syrians in Aleppo found that 38.7% smoked cigarettes or a water-pipe (19.2% of women, and 63.6% of men)[9]. Therefore, the level of smoking amongst the participants may be due to the disproportionate number of males. Smoking has many long-term consequences including increased likelihood of developing cancer, COPD, and cardiovascular disease. In contrast, a relatively small number of refugees (14%) consume alcohol. In a survey conducted in 2014/2015, it was estimated that 62.1% of Irish adults have consumed alcohol.

Implications and Recommendations

While there appears to be relatively low levels of reported physical health problems, comparing these to the GP assessments and to similar data from Syrian Refugees in Norway and the Lebanon suggests the following:

- There are high levels of smoking among the Syrian Refugee population, which may lead to higher rates of morbidity and chronic conditions in the future.
- Immediate requirements for health care relate to dental health, maternity care and mental health. Additional services may need to be planned in these areas.
- Social environment impacts on acculturation and on health[14-21] and respondents to our survey in particular noted dissatisfaction with their living environment and financial situation. A focus on this area may return notable benefits to their health and integration. This extends across Governmental Departments and services.
- While self-reported mental illness was low, symptoms such as 'difficulty falling asleep', 'feeling hopeless about future' and a 'sudden emotional or physical reaction when reminded of the most hurtful or traumatic events' were experienced by almost one third of respondents. There is also a relatively high prevalence of headache and use of medications, along with 18% of respondents having 'psychological distress'. Such factors need to be considered and monitored. Possibly, information leaflets containing the most common mental health issues (revealed in this study), explanations regarding these issues and use of medication could be distributed in the EROC centres. The information leaflets could also include names of outreach services which provide psychoeducational information on mental health services available to refugees.
- While the need for additional health related services in EROCs is indicated as required, there is also the need to prepare more widely for when Syrian individuals and families move from the EROCs into the community. Under the PHE, the HSE Office for Social Inclusion and the ICGP are preparing information for GPs and online material to create awareness about both the health requirements of this group but also the services and supports available. This will be finalised by mid-2019.

References

1. Department of Justice and Equality. Irish Refugee Protection Programme - Expressions of Interest Sought [Internet]. Dublin: Department of Justice and Equality; [cited 2018 Sep 5]. Available from: http://www.justice.ie/en/JELR/Pages/Irish_Refugee_Protection_Programme_(IRPP)

2. Department of Justice and Equality. Press releases [Internet]. Dublin: Department of Justice and Equality; 2016 [cited 2018 Sep 5]. Available from: http://www.inis.gov.ie/en/INIS/Pages/T%C3%A1naiste%20confirms%20plans%20to%20accept%20260%20more%20refugees%20under%20resettlement%20programme

3. International Organisation for Migration (IOM). Resettlement [Internet]. Dublin: International Organisation for Migration [cited 2019 Mar 3]. Available from: http://iomireland.ie/what-do-we-do/resettlement/

4. United Nations Office for the Coordination of Humanitarian Affairs [OCHA]. Syrian Arab Republic: The Humanitarian Crisis in Syria [Internet]. United Nations Office for the Coordination of Humanitarian Affairs; 2018 [cited 2019 Mar 3]. Available from: https://www.consilium.europa.eu/media/34016/syria-crisis_180423_v9.pdf

5. European Commission. The Eu and the migration crisis. [Internet]. Directorate-General for Communication (European Commission);2017 [cited 2019 Mar 3]. Available from: https://publications.europa.eu/en/publication-detail/-/publication/e9465e4f-b2e4-11e7-837e-01aa75ed71a1

6. European Commission. Commission Recommendation of 8.6.2015 on a European resettlement scheme. Brussels: European Commission, 2015.

7. Commissioner for Human Rights: Report of the Commissioner for Human Rights of the Council of Europe Dunja Mijatovic following her visit to Greece. Strasbourg: Council of Europe, 2018.

8. Department of Justice and Equality. Resources and services for the Emergency Reception and Orientation Centre in Ballaghaderreen [Internet]. Dublin: Department of Justice and Equality; 2017 [cited 2019 Mar 3]. Available from: http://www.justice.ie/en/JELR/Pages/SP17000022

9. Taleb ZB, Bahelah R, Fouad FM, Coutts A, Wilcox M, Maziak W. Syria: health in a country undergoing tragic transition. International Journal of Public Health. 2015 Jan 1;60(1):63-72.

10. Alpak G, Unal A, Bulbul F, Sagaltici E, Bez Y, Altindag A, Dalkilic A, Savas HA. Post-traumatic stress disorder among Syrian refugees in Turkey: a cross-sectional study. International Journal of Psychiatry in Clinical Practice. 2015 Jan 2;19(1):45-50.

11. Health Service Executive. Primary Care Eye Services Review Group Report 2017. Dublin: Health Service Executive; 2017.

12. Georgiadou E, Morawa E, Erim Y. High manifestations of mental distress in Arabic asylum seekers accommodated in collective centers for refugees in Germany. International Journal of Environmental Research and Public Health. 2017 Jun 7;14(6):612.

13. HSE Tobacco Free Ireland Programme (2018). The State of Tobacco Control in Ireland. Health Service Executive.

14. Department of Health, Ipsos MRBI. Healthy Ireland Survey 2017 Summary of Findings. Dublin: Department of Health; 2017.

15. Stewart M, Anderson J, Beiser M. Multicultural meanings of social support among immigrants and refugees. International Migration. 2008;46:123-59.

16. Warner FR. Social support and distress among Q'eqchi' refugee women in Maya Tecun, Mexico. Med Anthropol Q. 2007;21(2):193-217.

17. Davis RE. Refugee experiences and Southeast Asian women's mental health. West J Nurs Res. 2000;22(2):144-62; discussion 62-8.

18. Gerrand V. Book review: Refugee Mental Health in Resettlement Countries. International Social Work. 1988;31:238.

19. Stein B. The refugee experience: defining the parameters of a field of study. International Migration Review 1981;15:320-30.

20. Wu Z, Penning MJ, Schimmele CM. Immigrant status and unmet health care needs. Canadian Journal of Public Health = Revue canadienne de sante publique. 2005;96(5):369-73.

21. Stewart M. Social network, social support, and health. Can J Nurs Res. 2009;41(3):7-9.

Appendix 1: Demographic information for all refugees

	%	n
Gender		
Female	40.7	127
Male	59.3	185
Age group		
16/17	5.1	16
18-24	31.7	99
25-34	35.9	112
35-44	15.7	49
45-54	7.4	123
55-64	2.9	9
65+	1.3	4